

HAI High Sign



**News from the Virginia Department of Health
Healthcare-Associated Infections and Antimicrobial Resistance Program**

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Upcoming Events:

March 10-16	Patient Safety Awareness Week
March 30	National Doctors Day
April 1-7	National Public Health
September 12-13	Long-Term Care Training

Notes from VDH

We continue to expand the topics included in the HAI High Sign in order to cover conditions relevant across the healthcare spectrum. Please let us know if there are topics you would like covered.

Much of the information in this newsletter is relevant to frontline providers, and we need your help in order to reach them.

- Anyone can [sign-up to receive the newsletter](#), and we ask that you spread the word. To receive the next edition of the newsletter, **sign-up by May 1st**.
- Many of our partners forward the newsletter to their listservs, and we encourage you to do the same as relevant.

Please encourage infectious disease physicians, nurses, and pharmacists to [sign-up to be part of the Stewardship Interest Group of Virginia \(SIGoVA\)](#). SIGoVA is a group of clinicians who actively practice Antimicrobial Stewardship or have an interest in stewardship best practices in Virginia. The group originally formed in 2012 with the goal of sharing best practices and collaborating with other practitioners. Mobilize® is a new listserv platform that SIGoVA adopted in 2018. Through Mobilize®, members can post summaries of recent journal club articles, make announcements, post questions, post surveys, and much more. All members are welcome to participate!

Call for volunteers: We are looking for frontline providers who would be willing to give the VDH HAI/AR Program and Virginia HAI Advisory Group input on topics that impact you and your patients, including educational needs. The time commitment would be minimal; short conference calls will be scheduled when there is a specific topic to discuss, and you will have the option to provide input via email. We are recruiting frontline providers across care settings and disciplines. [Find out more information and see sign up instructions here.](#)

To contact us, email hai@vdh.virginia.gov. Thank you for your ongoing collaboration!

Tuberculosis and Newcomer Health Program Announcements

- Reminder: Latent tuberculosis infection (LTBI) became reportable in Virginia on [November 14th, 2018](#). Please provide reports of TB infection to your [local health department](#) via the [online portal](#) or through your normal communication route. For more information on how and what to report, as well as information on testing and treatment, please visit the TB Infection page of our [website](#).
- Annual surveillance reports as well as TB rates and case counts by county are available on the Data and Reports page of our [website](#) through 2017. 2018 counts and rates will be available in March to assist you with facility assessments. Please contact Laura Young with additional TB data requests or questions at laura.r.young@vdh.virginia.gov.
- Contact information for TB and Newcomer Health Program staff is available on our [website](#).
- [Watch a recent webinar](#) on identifying, reporting and treating TB.



Funding for Antibiotic Resistance Investments

The CDC recently updated their Antibiotic Resistance (AR) Investments website to include their 2018 data and investments. This website includes detailed information on how the CDC supports AR activities throughout each state and a variety of localities. Through an interactive map or a detailed PDF, viewers can see an overview on funding to state health departments, universities, and healthcare partners. This website also offers details on the AR Laboratory Network including the services offered at each regional lab.

Check out [Virginia specific initiatives](#)!

Maintaining Vaccine Coverage Among Healthcare Workers

As the [recent measles outbreak in the Pacific Northwest](#) has indicated, measles is still a threat in the U.S. In an effort to reduce transmission, we would like to remind all healthcare providers of the importance of maintaining measles immunity across their staff. All healthcare workers should be able to provide evidence of measles immunity, and employees unable to do so should receive two doses of the MMR vaccine.

It is important to note that healthcare workers are at a higher risk of being exposed to measles than the general population. Given the highly communicable nature of the virus, unvaccinated staff could quickly transmit the illness to friends and family, patients, and coworkers. As a result, healthcare workers without documented vaccination or immunity who are exposed to measles may be furloughed at the recommendation of the health department or their employer.

Of course, measles is not the only vaccine-preventable disease of importance in the healthcare setting. It is recommended that all healthcare workers review their vaccination history for other vaccine preventable diseases such as diphtheria, pertussis, varicella, mumps, rubella, hepatitis A, and hepatitis B.

Immunized staff are not only a barrier to transmission, but also serve as role models for patients and members of their community. Raising awareness and maintaining high vaccination coverage among healthcare workers reduces the burden of disease, contributes to reduced healthcare costs, and ensures the protection of patients and fellow employees.

For more information visit [CDCs website on recommended vaccines for healthcare workers](#).

Best Practice

Immunization coverage assessments should be performed upon hire and annually to ensure personnel are adequately immunized.

2019 Recommended Immunization Schedule

The Advisory Committee on Immunization Practices (ACIP) released the 2019 recommended immunization schedules for adults, children and adolescents. The ACIP highlighted the changes from the 2018 schedule:

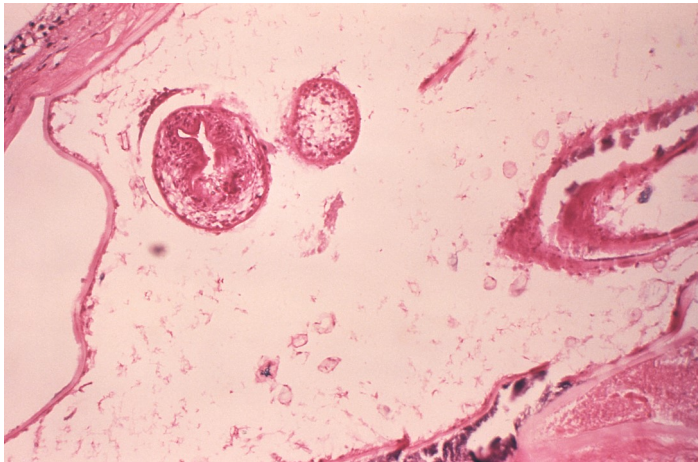
Adults	<p>The changes to the schedule from 2018 to 2019 include new recommendations for the:</p> <ul style="list-style-type: none"> • Live attenuated influenza vaccine • Hepatitis B vaccine • Hepatitis A vaccine
Children and Adolescents	<p>The changes to the schedule from 2018 to 2019 include clarification for the inactivated poliovirus vaccine recommendations, and revised recommendations for the:</p> <ul style="list-style-type: none"> • Hepatitis A vaccine • Hepatitis B vaccine • Influenza vaccine • Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap)

Read more about the [children and adolescent schedule](#), and the [adult schedule](#).

First *Echinococcus multilocularis* case in Virginia

In November 2018, a dog from Clarke County, Virginia was laboratory confirmed with *Echinococcus multilocularis*. While this tapeworm is known to exist in the north central region of the United States, as well as parts of Alaska, this is the first reported case of this zoonotic tapeworm in the mid-Atlantic region. In addition, the dog's travel history would indicate that the infection was acquired locally.

Adult *Echinococcus multilocularis* is typically found in the small intestine of wild canines (e.g., foxes, coyotes), which are the definitive hosts of the parasite. Dogs, and more rarely cats, can also serve as definitive hosts for the adult worm if the larval stage is ingested. The normal intermediate host is a small rodent (often voles or mice), however, if exposed, other mammals, such as people, may become aberrant, intermediate hosts. Following ingestion of eggs by an intermediate host, the larval (metacestode) stage develops by exogenous budding, usually in the liver. Locally acquired human *Echinococcus multilocularis*



This photomicrograph of a larval lesion that was on a vole, which was experimentally infected with the parasite, *Echinococcus multilocularis*. The larval stage of this microscopic tapeworm is one of the causative agents of alveolar hydatid disease (AHD), an infection in humans that causes parasitic tumors to form, mainly in the liver, but can also appear in other organs as well. Photo credit: CDC/ Dr. Peter Schantz

infection in North America is considered rare and, to date, only one human infection is thought to have been acquired in the U.S. Infection can often result in severe outcomes such as liver failure.

The Virginia Department of Health (VDH) and animal health partners in Virginia are collaborating to assess the burden of this parasite through surveillance in domestic dogs as well as wild canines, like foxes and coyotes. Assessing the burden will help inform the likelihood of human infection as well as the need for other infection control interventions.

Like with any pathogen that is transmitted via the fecal-oral route, routine handwashing is an important infection prevention measure. VDH will distribute additional information about the burden of this parasite in Virginia as it becomes available. For more information about Echinococcus multilocularis, please visit:

<https://www.uptodate.com/contents/clinical-manifestations-and-diagnosis-of-echinococcosis>

<https://www.cdc.gov/parasites/echinococcosis/index.html>

CDC Reminder Concerning the Ongoing Ebola Outbreak in Africa

In response to the ongoing outbreak of Ebola virus disease (EVD) in the Democratic Republic of Congo (DRC), the Centers for Disease Control and Prevention (CDC) [sent a reminder for healthcare facilities](#) to review infection prevention plans and procedures to identify and manage patients with communicable infections.

This communication is provided as an update about CDC infection prevention guidance and related concerns pertinent to U.S. healthcare facilities and associated personnel.

The reminder includes infection prevention considerations for:

- Initial triage of patients
- Current infection prevention and control recommendations for Ebola virus disease in the U.S.
- The Regional Treatment Network for Ebola and other special pathogens

In addition, note resources provided in the communication:

[Main CDC EVD portal](#)

[World Health Organization's Ebola Situation Reports](#)

[CDC Travel Notice for the current outbreak in DRC](#), including special recommendations for healthcare personnel and sponsoring organizations in the outbreak area

The National Institutes of Health (NIH) open-label clinical trial, "[Pre-Exposure Prophylaxis in Individuals at Potential Occupational Risk for Ebola Virus Exposure](#)"

Updated Clinical and Laboratory Standards Institute (CLSI) Performance Standards for Antimicrobial Susceptibility Testing

CLSI has released their updated antimicrobial susceptibility testing standards. Discussions surrounding the implementation plan for these updates should include, at a minimum, the clinical microbiologist, the physician in-charge of antimicrobial stewardship activities, and the pharmacist in-charge of antimicrobial stewardship activities at the facility. Major changes to the guidelines are listed below.

New Breakpoints

- Meropenem-vaborbactam: disk diffusion and MIC breakpoints for Enterobacteriaceae
- Azithromycin: MIC breakpoints for *N. gonorrhoeae*
- Cefiderocol: investigational MIC breakpoints for Enterobacteriaceae, *P. aeruginosa*, *Acinetobacter spp.*, and *Stenotrophomonas maltophilia*

Revised Breakpoints

- Ciprofloxacin/levofloxacin: Lowered breakpoints for Enterobacteriaceae and *P. aeruginosa*
- Daptomycin: Added susceptible-dose dependent (SDD) category for *Enterococcus spp.*
- Ceftaroline: Added susceptible-dose dependent (SDD) category for *S. aureus*

Updated Guidance

- Ceftazidime/avibactam: Disk diffusion may overcall resistance for isolates; added instructions for performing MIC testing when specific disk diffusion zone diameters are observed for Enterobacteriaceae
- Fosfomycin: reinforced the comments that fosfomycin disk diffusion and MIC breakpoints are for *E. coli* urinary tract isolates only
- Colistin MICs can be used as a surrogate for polymyxin B when testing *P. aeruginosa*, *Acinetobacter baumannii*, and select members of the Enterobacteriaceae

[Find more detailed information here.](#)

Expected Practice as a Novel Antibiotic Stewardship Intervention

Antimicrobial stewardship programs (ASP) have been looking towards new strategies using psychological tools to alter provider behavior as a way to increase optimal antibiotic prescribing. The Los Angeles County + University of Southern California (LAC+USC) Medical Center recently published their findings on using a newly described method called “expected practice”. Expected practice sets an institution’s expectation for how its providers practice medicine. These expected practices set stronger standards of care when compared to clinical guidelines.

This facility developed expected practice on antibiotic durations. The group that developed the expected practice was comprised of representatives from primary care and infectious diseases committees, with ultimate approval by the hospitals’ Pharmacy and Therapeutics Committee and Medical Executive Committee. Expected practice guidance was sent to all outpatient and inpatient clinicians. An example of this document is included in Table 1. Deviations from antibiotic duration were to be explicitly clinically justified.

Table 1. Expected Practice For Antibiotic Duration of Therapy

Disease	Expected Duration of Antibiotic Therapy (days)	Comment
Community Acquired Pneumonia	5	Not studied for ICU/ventilated patients
Acute Bronchitis	0	Routine antibiotic treatment of acute bronchitis is NOT indicated
Cystitis	1-5 days	5 days of nitrofurantoin, 3 days of TMP-SMX, 1 dose of fosfomycin, or 1 dose of IV ceftriaxone or an aminoglycoside is sufficient

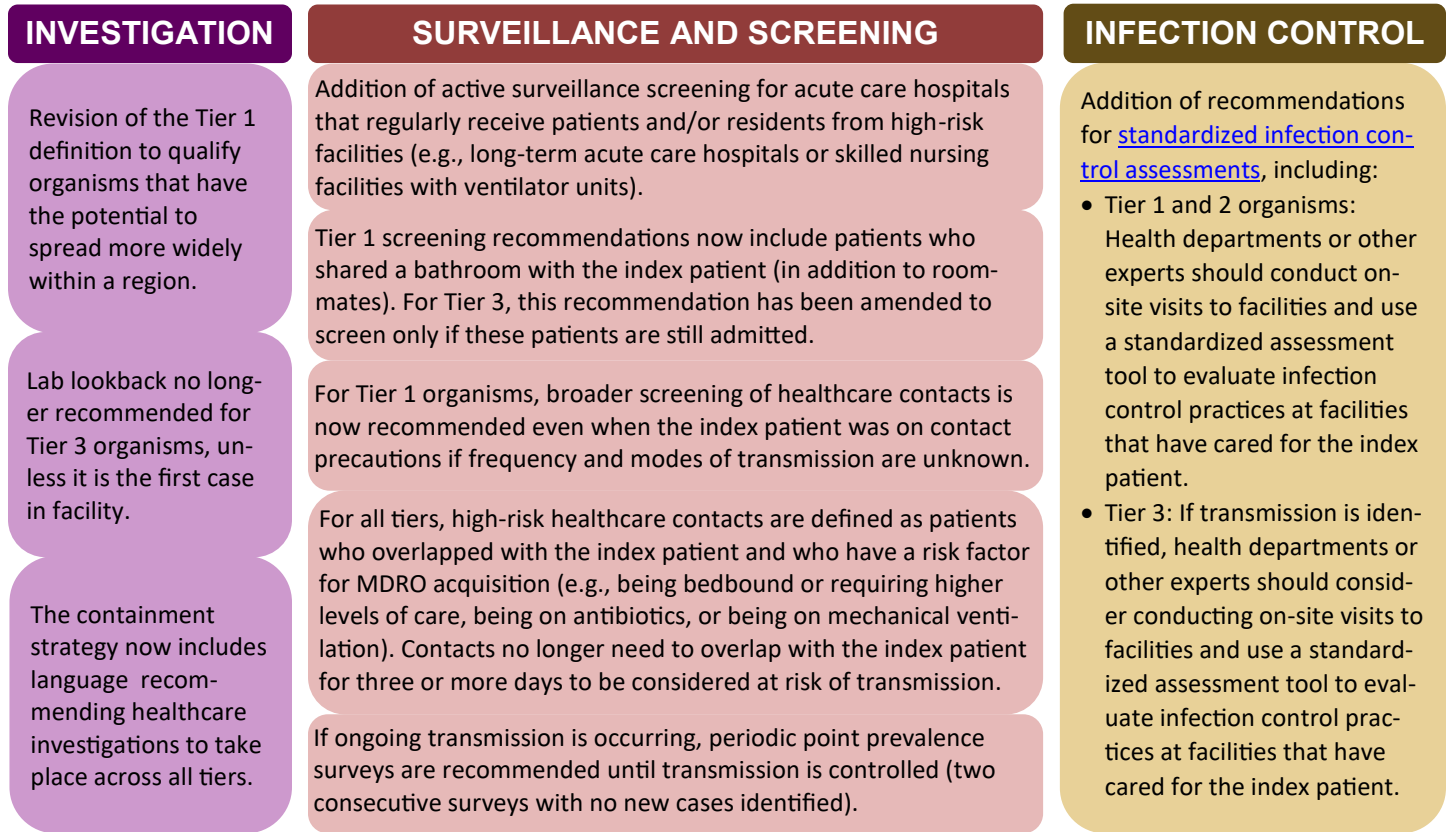
Patient information was collected for the 12-month period before expected practice implementation and the 12-month period after implementation.

Using a pre/post quality improvement study design, the authors reported a statistically significant decrease in antibiotic days of therapy for the following conditions: urinary tract infections, skin and soft tissue infections, and pneumonia. Expected practice requires no additional technology or money to implement and alleviates concerns surrounding blame the providers might receive if they prescribed short-course antibiotic therapy that resulted in poor clinical outcomes.

Using the guidance set forth by LAC+USC Medical Center, facilities in Virginia could implement similar strategies. [Read more about the study here.](#)

CDC Updates Containment Strategy Guidelines

The Centers for Disease Control and Prevention (CDC) published the Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDROs) in 2017. It is the basis for the national containment strategy which the Virginia Department of Health uses to respond to a single case of a carbapenemase-producing organism, *Candida auris*, or vancomycin-resistant *Staphylococcus aureus* (VRSA). On February 6, 2019, [CDC published updates to this guidance](#). These include and are summarized in the figure below:



CDC Containment Strategy Recommendations Summary

	Tier 1			Tier 2				Tier 3
	Novel Resistance	VRSA	Pan-resistance	CP-CRPA (NDM, VIM, IMP, OXA, KPC)	CP-CRE (NDM, IMP, OXA, VIM)	<i>C. auris</i>	<i>mcr</i> -type genes	CP-CRE (KPC)
Healthcare investigation	Always	Always	Always	Always	Always	Always	Always	Always
Prospective surveillance	Always	Always	Always	Always	Always	Always	Always	Always
Retrospective lab surveillance	Always	Always	Always	Always	Always	Always	Always	Sometimes
Onsite Infection Control Assessment with observations of practices	Always	Always	Always	Always	Always	Always	Always	Sometimes
Screening of healthcare roommates	Always	Always	Always	Always	Always	Always	Always	Always
Broader screening of healthcare contacts	Always	Sometimes	Sometimes	Sometimes	Sometimes	Always	Sometimes	Sometimes
Household contact screening	Always	Sometimes	Sometimes	Rarely	Rarely	Rarely	Rarely	Rarely
Environmental sampling	Sometimes	Rarely	Rarely	Rarely	Rarely	Rarely	Rarely	Rarely
Healthcare personnel screening	Sometimes	Sometimes	Rarely	Rarely	Rarely	Rarely	Rarely	Rarely

To learn more about the CDC Containment Strategy click [here](#).



Patient Door Side Multidisciplinary Rounds at the UVA Transitional Care Hospital

Brenda Heon, RN, IP

We care, we are present, we hear concerns

The UVA Transitional Care Hospital (TCH) is a long-term acute care hospital (LTACH). The patients served have a longer hospital stay (average 28 days), are often immunocompromised, and have a history of multiple hospitalizations. Due to these factors, patients are often at a greater risk for infection. TCH started using door side multidisciplinary rounds in 2014 with the goal of establishing an efficient form of communication involving all disciplines while optimizing patient outcomes.

Multidisciplinary rounds take place at the door side of every patient room at TCH on Tuesday and Thursday mornings. The multidisciplinary team includes a physician, pulmonologist, wound ostomy nurse, infection preventionist, certified diabetes nurse educator, pharmacist (also part of antibiotic stewardship), chaplain, dietician, and respiratory therapist. The rounds often include the care partners and sometimes the patients themselves. The rounds serve as a forum to identify and implement daily and long-term goals for the patients.

TCH Wins Charles Brown Award for Door Side Rounds

TCH won the ninth annual Charles L. Brown Award for Patient Care Quality in 2015 for their dramatic decrease in device utilization and healthcare-associated infections seen following implementation of patient door side multidisciplinary rounds.

As an infection preventionist, I have the opportunity to observe hand hygiene in the moment, conduct isolation audits and address any infractions observed. Education is also provided to patients and care partners on hand hygiene and reasons for isolation. We have found that this practice also improves patient and care partner satisfaction. We continue to look at ways to improve our HAI and infection prevention measures for the benefit of our patients.

Strong Infection Prevention Culture at TCH

- Hands-on audit for central line and Foley catheter
- Presumptive contact precautions for all patients admitted to rule out MDRO
- Preventative *C. difficile* bed covers
- All rooms cleaned with bleach 2 days per week
- Daily CHG bath wipes on patients

Items discussed during rounds include discharge planning, ventilator weaning, and device utilization. There is often mention of alternative use of less invasive devices that might be best for the patient. In addition, the patient door side rounds are a perfect opportunity to remind staff the reason for isolation, review specific cultures, and review the multi-drug resistant organism (MDRO) clearance policy. As the infection preventionist, I have the opportunity to observe hand hygiene in the moment, conduct isolation audits and address any infractions observed. Education is also provided to patients and care partners on hand hygiene and reasons for isolation. We have found that this practice also improves patient and care partner satisfaction. We continue to look at ways to improve our HAI and infection prevention measures for the benefit of our patients.



New IDSA Guidelines on Influenza

The Infectious Diseases Society of America (IDSA) recently published new evidenced-based [guidelines on influenza](#) diagnosis, treatment, chemoprophylaxis, and outbreak management. These new guidelines are lengthy, but worth reading. A select few points from the recommendations are below.

- American Indian/Alaskan Native people are now considered at high risk for developing complications from influenza. The full list of high-risk groups can be found in [Table 4](#).
- Active surveillance for additional cases of influenza should begin in hospitals and long-term care facilities with the first lab-confirmed case of flu.
- Outbreak control measures, including post-exposure chemoprophylaxis, should begin with the second lab-confirmed case of flu in 72 hours in the same ward/unit. If confirmatory testing is not available, outbreak control measures can be initiated before confirmation.
- Facilities can have a wide variety of structural separations or none at all. PEP does not need to be administered in locations physically separate from the identified cases.
- These guidelines were written largely before baloxivir become available in the U.S., and as such, do not include it in the antiviral recommendations. A following addendum may address this.

Evaluation and Management of Penicillin Allergy

About 10% of the U.S. population has reported allergies to the β -lactam agent penicillin. The most common documented penicillin allergy reactions in electronic health records are: rash (38%), "unknown" (26%), hives (18%), angioedema (9%), gastrointestinal upset (6%), anaphylaxis (5%), and itching (5%).

As a component of antimicrobial stewardship efforts, evaluation of penicillin allergy leads to more appropriate antibiotic prescribing and may reduce antimicrobial resistance and cases of *C. difficile* infection.

A recent review in *JAMA* recommends the following evaluation and management of penicillin allergic patients.

β -lactam Allergy Facts

- Baseline risk for any reaction to β -lactam antibiotics is ~2%
- Cross-reactivity between penicillin and cephalosporin drugs occurs in about 2% of cases, less than the 8% reported previously
- More than 95% of patients who do not have a history of serious penicillin allergy reactions are penicillin tolerant
- IgE-mediated penicillin allergy wanes over time, with 80% of patients becoming tolerant after a decade
- Best practice for allergy histories include obtaining the time course of the reaction and the reaction phenotype

Approach to Patient With Penicillin Allergy

Yes

Allergy evaluation is not indicated. Do not perform any penicillin allergy testing. Avoid β -lactams.

Step 1. Does the allergy history include blistering rash, severe cutaneous adverse reactions (SCAR), hemolytic anemia, an organ-specific reaction (e.g., acute interstitial nephritis), drug fever, or serum sickness?

No

Proceed to Step 2.

Step 2. Stratify patients based on their allergy history, then proceed to Step 3.

High Risk

Anaphylaxis, positive penicillin skin testing results, recurrent penicillin reactions, and hypersensitivities to multiple β -lactam antibiotics.

Moderate Risk

Urticaria or other pruritic rashes or reactions with features of IgE-mediated reactions (e.g., swelling), but not anaphylactic reactions.

Low Risk

Isolated non-allergic symptoms (e.g., gastrointestinal symptoms) or patients solely with a family history of a penicillin allergy, pruritus without rash, or remote (>10 years) unknown reactions without features suggestive of an IgE-mediated reaction.

Step 3. Use stratified risk to determine recommendation.

High Risk

Patient should be evaluated by specialist, desensitization procedure might be pursued.

Moderate Risk

Perform skin test and if negative, amoxicillin challenge.

Low Risk

Prescribe β -lactam or perform a direct amoxicillin challenge.

For more information about these recommendations, click [here](#).

NHSN Notes

Data Quality Update

Thank you to all the IPs who reviewed their hospital's 2018Q3 data cleaning report and submitted their acknowledgment form. We appreciate all the work you do to collect, enter, and quality assure HAI data for your hospital. **Please remember to update the HAI/AR Team with any IP contact changes.**

The deadline to enter **2018Q4** data into NHSN for the CMS Quality Reporting Programs for participating acute care hospitals, long-term acute care facilities, and inpatient rehabilitation facilities is **May 15, 2019**. May 15 is also the deadline to enter healthcare personnel influenza vaccination data into NHSN.

NHSN Seeking Input on Bloodstream Infection (BSI) and Outpatient Procedure Component Surveillance Protocols

NHSN sent an email to users in February describing the opportunity for facilities, groups, and individuals to identify issues and areas for potential improvement for consideration as CDC updates and maintains the Bloodstream Infection (BSI) surveillance and new Outpatient Procedure Component (OPC) protocols for 2020. Comments may be submitted for consideration via the Federal Register through Monday, April 15, 2019. This will be the only format for submitting suggested modifications or comments regarding these two types of surveillance for 2019. Users submitting comments/suggested protocol changes to NHSN@cdc.gov will be referred to the Federal Register while it is active. The protocols are found at these locations:

BSI: [Click here](#)

OPC: [Click here](#)

Please [click here](#) for more information or to submit a comment. Follow the instructions provided.

Feedback Requested from Facilities

We would love to hear from you!

- How have you used NHSN in your prevention efforts? We would love to highlight your success stories in our newsletter.
- How can VDH help you use your data for action?
 - Does your infection prevention staff need training and technical assistance on the NHSN protocols?
 - Are there any topics related to NHSN surveillance and reporting that you would like for us to host a webinar on?
 - Do you have any ideas for new data reports or suggestions to improve the current VDH data reports?

Please send any comments or suggestions to the HAI/AR Team at HAI@vdh.virginia.gov.

Updated Guidance for Healthcare Personnel Influenza Vaccination Reporting

In the last HAI High Sign newsletter, we included information on recent changes to Centers for Medicare and Medicaid Services (CMS) reporting requirements for healthcare personnel (HCP) influenza vaccination summary data. Outpatient departments of acute care facilities were included in the list of facilities no longer required to report HCP influenza vaccination summary data to NHSN beginning with the 2018-2019 influenza season.

New guidance from CMS and CDC have been provided to clarify that the HCP measure is a **facility-wide measure** and does not separate out employees who only work in the inpatient or outpatient areas or work in both.

Beginning with the current 2018-2019 influenza season, users should follow the guidance below when making determinations about which areas of the acute care facility to include when reporting HCP influenza vaccination summary data to NHSN as part of the Hospital Inpatient Quality Reporting Program:

- **Include** all inpatient units/departments of the acute care facility sharing the exact same CCN (100% identical) as the acute care facility, regardless of distance from the facility.
- **Include** all outpatient units/departments of the acute care facility sharing the exact same CCN (100% identical) as the acute care facility, regardless of distance from the facility.
- **Exclude** all inpatient and outpatient units/departments of the acute care facility with a different CCN (even if different by only one letter or number) from the acute care facility.

This guidance supersedes any specific information that CDC had provided regarding reporting for the CMS Hospital Inpatient Quality Reporting Program, including information presented during the January 2019 webinars that CDC hosted for acute care facilities.

The deadline for submitting HCP influenza vaccination data in NHSN for the 2018-2019 flu season is **May 15, 2019**.

Please check out the [training materials](#) incorporating this guidance.

If you have further questions about this reporting, please contact the following groups:

- NHSN: nhsn@cdc.gov (Please include 'HPS Flu Summary-Acute Care' in the subject line of your message)
- CMS support contractor for the Hospital Inpatient Quality Reporting Program: InpatientSupport@viqrc1.hcqiis.org or toll-free at (844) 472-4477

Save the Date for Upcoming Events and Recognition Weeks

Patient Safety Awareness Week

March 10-16, 2019

Patient Safety Awareness Week, designed to encourage everyone to learn more about healthcare safety, is an annual recognition initiative from the Institute for Healthcare Improvement. During this week, important education and discussion is designed to spur action to improve the safety of the healthcare system. Commitment to patient safety across care settings requires coordinated and collaborative responses to ensure significant reductions in health care harm such as healthcare-associated infections (HAIs).

Learn more about [Patient Safety Awareness Week!](#)

National Doctors' Day

March 30, 2019

Doctors' Day, an annual recognition in the United States is celebrated on March 30. This recognition dates back to 1933 and was established to recognize physicians for their dedicated work and contributions to our communities.

Take this opportunity to say, "thank you" to your physicians for all that they do providing healthcare and improving well-being!

National Public Health Week

April 1-7, 2019

Mark this week to work together to build healthier communities promoting longer lives in safer environments. Each day of National Public Health Week will focus on a specific public health topic such as healthy communities and violence prevention.

Visit the [National Public Health Week Website](#) to view the daily 2019 themes and identify ways to contribute to make a difference in these endeavors.

Bridge the Gap: Countdown to New Requirements for Long-Term Care Infection Preventionists



The March training is full, but there is an additional training being offered September 12-13, 2019.

[Sign up today!](#)

[Preview the agenda](#)

Healthcare-Associated Infections and Antimicrobial Resistance Program

<http://www.vdh.virginia.gov/clinicians/>

hai@vdh.virginia.gov | (804) 864-8141

<http://www.vdh.virginia.gov/surveillance-and-investigation/hai/>



Seth Levine, Epidemiology Program Manager
Sarah Lineberger, HAI Program Manager
Shaina Bernard, AR Coordinator
Carol Jamerson, HAI Nurse Epidemiologist
Rehab Abdelfattah, Clinical Investigations Consultant
Virgie Fields, HAI Epidemiologist
Emily Valencia, AR Epidemiologist
Tisha Mitsunaga, CDC/CSTE HAI Epidemiology Fellow
Christina Martone, HAI/AR Policy and Prevention Specialist
Kurt Steigerwalt, HAI Program Assistant